2015 Health Homes Listening Tour Report

Introduction

Medicaid Health Homes (HHs) for people with serious mental illness (SMI) were implemented in Kansas July 1, 2014. The Kansas model for HHs is a partnership between Lead Entities (the three KanCare managed care organizations – MCOs) and community Health Home Partners (HHPs). Each MCO has around 60 contracted HHPs, although not all 60 HHPs contract with all three KanCare MCOs.

The SMI HH programs in Kansas employs a passive enrollment/opt out feature whereby eligible members are identified by the Lead Entities, sent an assignment letter and allowed to opt out at any time if they do not wish to be in a HH. As of July 2015, there were 36,573 people identified as eligible for HHs and 30,083 enrolled; however, not all those enrolled are actively engaged in HHs. This lack of engagement can be because the person is difficult to find due to an address or phone number not being updated in the Medicaid enrollment file or to the person's distrust or suspicion of the program, the HHP or government programs in general. Eighteen percent of those eligible have opted out of HHs. More information about the Kansas SMI HH can be found at: **http://www.kancare.ks.gov/health_home.htm** .

Most HHPs are Community Mental Health Centers (CMHCs). Other HHPs include providers of service to people with IDD, Federally Qualified Health Centers (FQHCs) and one statewide provider of services to people with substance use disorders. Each of them is working to engage difficult-to-engage members and provide holistic care coordination that includes making sure physical and behavioral health needs are met, as well as ensuring their community and social support needs are provided for.

The Kansas Department of Health and Environment's Division of Health Care Finance (KDHE DHCF) launched a brief online survey of HHPs in February 2015 to learn how HHPs believe the program is working. Approximately 70% of HHPs responded. Table 1 below indicates the number of members served by all HHP types who responded to the survey and Table 2 details the number of members the two most common HHP types reported having on their rosters.

Table 1. Number of Members Served by all Provider Types

Approximate number of members served by Health Homes—All Provider Types		
Answer Options	**Response Percent**	**Response Count**
1 - 50	31.0%	13
51 - 100	14.3%	6
101 - 250	11.9%	5
251 - 500	7.1%	3
501 - 1000	21.4%	9
More than 1000	14.3%	6

Table 2. Number of Members Served by CMHCs and CSP-IDD Providers

Approximate number of members served by CMHC Health Home programs

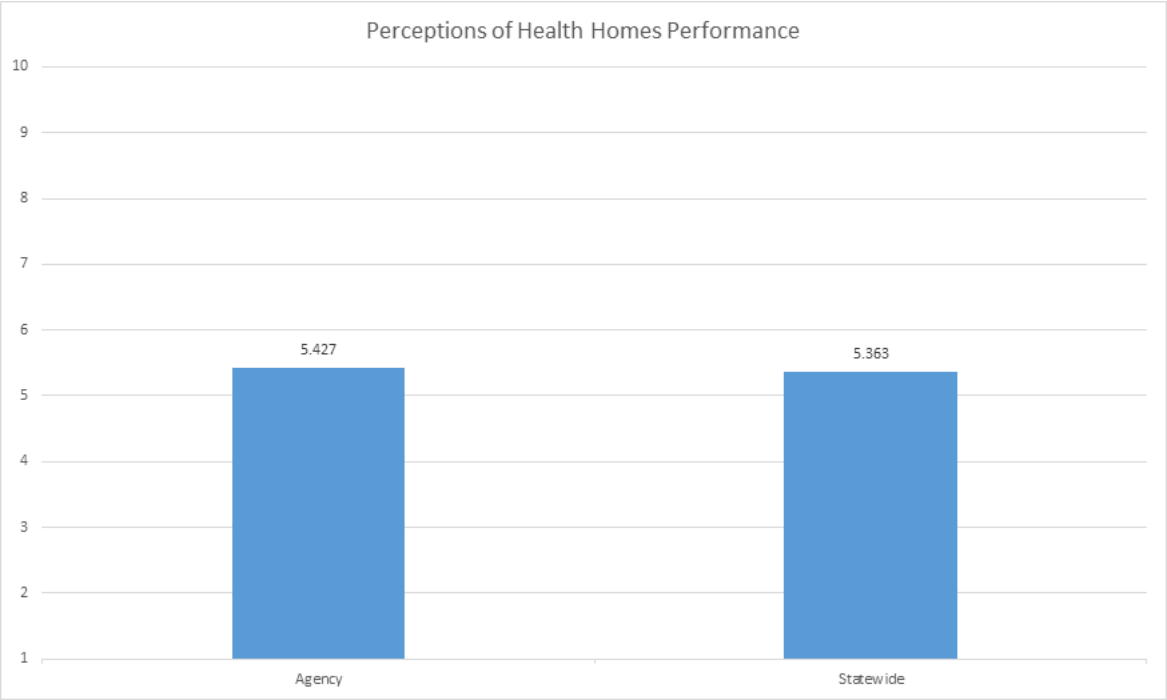
Answer Options	Response Percent	Response Count
1 - 50	0	0
51 - 100	0	0
101 - 250	15.8%	3
251 - 500	10.5%	2
501 - 1000	47.4%	9
More than 1000	26.3%	5

Approximate number of members served by CSP-IDD Health Home programs

Answer Options	Response Percent	Response Count
1 - 50	78.6%	11
51 - 100	21.4%	3
101 - 250	0	0
251 - 500	0	0
501 - 1000	0	0
More than 1000	0	0

HHPs were asked to rate their perceptions of how the program was performing on a scale of 1 (not very well) to 10 (very well) within their individual agencies and statewide. Figure 1 below shows that the average perception of how the Health Homes program is performing at the individual HHP level is similar to the average perception of how it is performing statewide.

Figure 1. HHP Perception of Health Home Program Performance



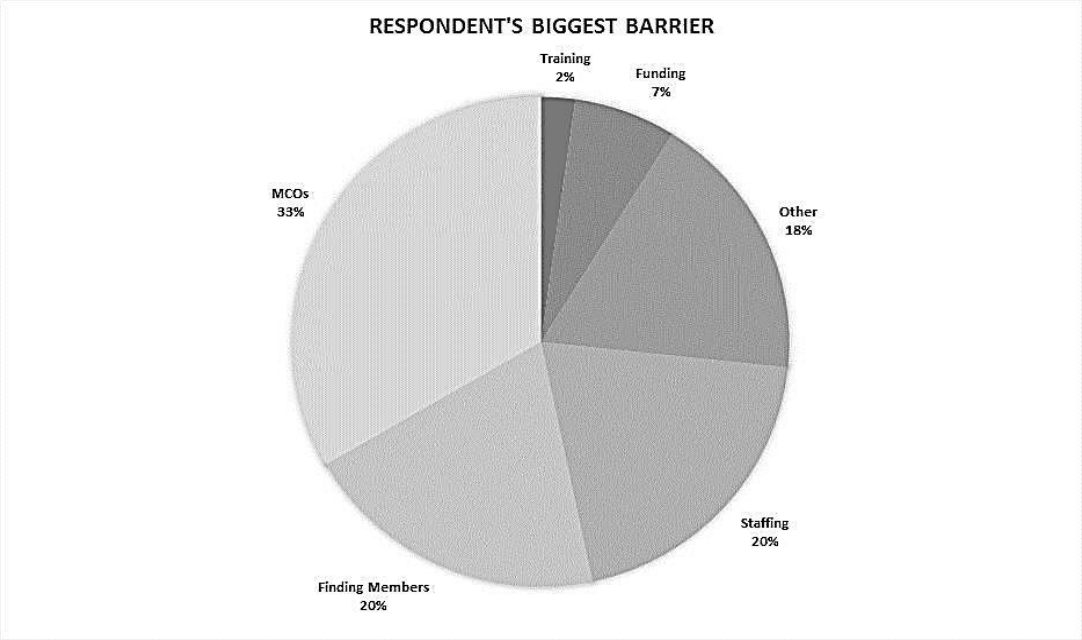
The survey also asked HHPs to indicate what they believed was the biggest barrier in providing HH services. The survey gave respondents the choices of:

- Staffing
- Funding
- Training
- Other (with a text box)

Review of the "Other" responses showed they could be broken down into MCO-related issues, finding members and a further category of "Other," comprised of many unrelated responses.

Figure 2 illustrates what percent of each of these groupings comprised.

Figure 2. Issues Reported as Biggest Barriers to Providing HH Services



After the survey results were analyzed, KDHE scheduled meetings at 22 cities across Kansas. Each meeting was hosted by a HHP, and all HHPs contracted to provide HH services to the SMI population were invited to attend the two-hour meetings. Appendix A contains the list of the attending HHPs. The majority of the meetings were small, although a few meetings involved 15 or more HHP staff. Appendix B details the actual attendance numbers for each meeting. The invitation included an agenda with a specific set of questions so the HHP staff could come prepared to answer the questions. This agenda can be found in Appendix C. The meetings were conducted in a quasi-focus group manner, ensuring that all attending HHPs were afforded an opportunity to respond to each question. Notes from each meeting were compiled and then categorized into major themes which were then shared with the three MCOs - Amerigroup, Sunflower State Health Plan and United Healthcare. The themes related to problems or barriers were also prioritized in order to determine where the most attention should be focused.

Major Successes

HHP staff was asked to share some major successes in the latter part of each meeting. These could be individual member success stories or successes related to the HH operation itself. Many HHPs spoke of individual member success, such as a 500-pound woman who had been housebound for so long her diabetes was out of control and she was embarrassed to leave her home. The HHP found a mobile health provider who came to the home and performed blood work and other tests. This member is now connected to a Primary Care Provider (PCP) and on the way to better health. One IDD HHP reported significant reductions in a member's recurring episodes of conjunctivitis and use of antibiotics through helping the member understand the importance of hand washing.

Other successes related to changes within the HHP agency itself, such as behavioral health therapists and case managers beginning to recognize the importance of physical health in the treatment of behavioral health conditions. Many HHPs shared successes in collaborating with other providers or community organizations, including other HHPs in their areas. Also seen as a success was that HH members are now taking an active role in the management of their own health, by asking for PCPs, letting HHP Care Coordinators know when they enter or have been in the hospital or calling the HHP before simply showing up at a hospital emergency department.

IDD CSPs who are HHPs also reported that HH services were especially significant for members who are on the waiting list for the IDD Home and Community Based Services (HCBS) waiver, providing these members with much more than targeted case management (TCM) alone can.

Specific successes are contained in the list below:

- Developed trust with an agoraphobic member who is now taking medication and working half-time
- Arranged after-care for a member following an inpatient stay for a foot injury that likely saved the member's foot
- Accessed dental care for members more frequently
- Found low-cost, charity care (e.g., dental, vision)
- Helped an obese child lose more than 40 pounds
- Helped a 500 pound member trapped at home with a mobile health unit
- Found members, completed basic health assessments, learned they have a major problem (e.g. high blood pressure) and arranged treatment
- Connected members to PCPs
- Took care of a member's dog so she could go into the hospital
- Culture change occurred in the HHP agency - other staff (e.g. case managers, therapists) now recognize the importance of their own health and that of the people they serve
- Helped members access already available services
- Helped with housing, legal issues, food
- Did more for members because payment structure provides more freedom
- Helped IDD members socialize through a dating website
- Identified unsafe living situations
- Identified prescribing errors
- Identified welfare fraud and exploitation of a HH member by family members
- Engaged members in creative ways in order to complete health assessments and begin setting Health Action Plan (HAP) goals
- Reduced conjunctivitis through hand washing education and practice

- Helped members get appropriate care at the appropriate place
- Provided smoking cessation groups or counseling
- Helped members learn to call HHP before going to ER or when an inpatient
- Helped members recognize poor eating habits through working on HAP goals
- Received a financial donation from a non-member who believes HHs are great
- Prevented suicide through support and listening
- Identified inappropriate SMI diagnoses
- Identified barriers to appropriate preventative care for some (e.g. IDD)
- Assisted in the reintegration a foster care child with family
- Provided training and support to new mothers with SMI
- Assisted the family of a very young member with housing, laundry facilities, job support, and documents
- Assisted a member with a neurological work-up and second opinion to confirm a seizure diagnosis
- Modeled how to interact with health care system and improved health literacy

Reaching Out to Other Community Providers

The first focus question asked of HHPs was "What are you doing to reach out to other community providers (e.g., hospitals, PCPs, foster care contractor case managers)?" From the early pre-implementation days of the program potential HHPs were encouraged to collaborate and communicate to area providers to let them know about HHs, the role of the HHP, and to establish regular lines of communication. This question was designed to determine how much of that work had occurred, either before implementation or since. Ways in which HHPs said they were interacting with other providers included:

- Going to PCP appointments with the member and educating providers at that time
- Sending letters to providers
- Speaking with providers in person
- Collaborating with other HHPs in the same area to speak to providers
- Offering to give presentations to other providers
- Targeting hospitals or ERs specifically
- Notifying pharmacies
- Sharing some staff with other providers or hiring people who used to work with other providers
- Providing in-house training to other areas of their agency
- Holding meetings with foster care contractors
- Taking trays of cookies to PCP offices or to all health care providers in the county
- Developing "cheat sheets" to give to providers about HHs
- Sending completed HAPs with HH information to PCPs
- Sending postcards to PCPs
- Collaborating more closely with providers with whom the HHP already has an established relationship (particularly true for IDD HHPs)

Marketing HHs to the Community

The second focus question asked "How are you marketing yourself to the community as a whole?" HHPs reported various ways they were doing this, although a number said they were

not yet marketing themselves because they were concentrating on building relationships with other providers. Marketing activities included:

- Getting newspaper articles written about the HHP
- Developing HH-specific newsletters, posters and brochures
- Creating public service announcements
- Participating in health fairs or the county fair
- Developing community gardens and offering cooking classes in conjunction with the local extension agency
- Offering a hot lunch program
- Speaking to community organizations (e.g. Rotary Club)
- Providing Chronic Disease Self-Management and Diabetes Self-Management training to members and non-members
- Planning a Facebook page

SMI HH Program Manual

KDHE developed a program manual to help guide the SMI HH program. The manual was not designed to cover every detail of the program since MCO contracts with HHPs and MCO provider manuals would govern much of the work. HHPs were asked "Do you find the program manual helpful?" and "Are there additional program-related topics you'd like to see addressed in the manual?" Most HHPs stated they found the manual useful in the beginning of the program, but now use it for reference or to train new staff. Some stated they use it to challenge the MCOs when the MCOs direct HHPs to do something HHPs believe they should not have to do. There were few ideas offered for additional information. Suggestions included adding:

- More transportation information
- Information from HHPs about tips and tricks they have found useful
- More information about the grievance and appeal process

Ways MCOs Can Help HHPs Provide Exceptional Service

The focus question that yielded by far the most feedback from HHPs was "What do you need from the MCOs to enable you to provide exceptional services to HH members?**"** There was a large variety of responses to this question, but they could be grouped into nine themes:

- Member lists
- Transportation
- MCO provider portals
- MCO responsiveness to HHPs
- Audits or reviews of HHPs
- Health Action Plans
- Difficulties accessing other services
- Roles of the Lead Entities (MCOs) and HHPs
- Education of MCO staff

Specific details were not elicited. State staff did not ask for particulars since the intent of the meetings was not to solve specific problems that had already occurred, but to gain a sense of how the program is working and what needs to be improved. A number of HHP staff indicated that, although the initial implementation of the HH program evidenced several problems, they had seen improvement over the eight and a half months the program had been operating.

An over-arching theme was that it is difficult for HHPs to deal with three MCOs who each have different processes and expectations. This is believed to create extra administrative burdens for the HHPs. The most often stated request was that the member lists from the MCOs need to improve because they require a great deal of time for HHPs to work through due to:

- Including duplicate members, although it has since been determined that this problem is likely due to the software being used by most of the CMHC HHPs and not an MCO issue
- Showing members who have opted out or for whom refusal forms have been sent
- Not including people who have been referred
- Coming out too late in the month for the HHP to be able to contact new members in that same month

The transportation issues cited included many concerns expressed about KanCare transportation services generally, but it also was clear that HHPs are not aware of the urgent transportation referral process that has been a part of KanCare since it's implementation.

The MCO provider portals received mixed ratings, but most HHPs indicated they did not like navigating three different portals. Two of the three portals were viewed as difficult to get into, or to navigate within.

HHPs also asked that MCOs be more responsive to them, noting that MCO staff is not consistent about returning phone calls or responding to e-mail from HHPs. Some HHPs stated they hadn't talked with an MCO since the program began. Other HHPs stated they saw MCO staff too frequently.

Primary concerns about MCO audits or reviews of HHPs included the amount of preparation the HHPs have to go through and that this work is multiplied by three. Some HHPs complained of "data creep" in the request MCOs were making related to materials for the audits.

A common request from HHPs related to completion of HAPs involved wanting more consistent direction from the State and the three MCOs.

HHPs also expressed frustration over problems accessing other KanCare services for their members. Often this involved trying to get a Value Added service and not being able to access it because MCO Customer Service was unhelpful. Some HHPs expressed ignorance about what Value Added services are available.

Many HHPs voiced concern that the MCOs do not view their relationship with HHPs as a partnership and the MCOs expect too much administrative work from the HHPs when they want to be working with members.

HHPs believe that MCO staff, from Customer Service to IDD Care Coordinators, needs more training about the Health Homes program. They pointed out MCO staff frequently confuse HHs with home health services or do not seem to know much about the program.

HHPs also offered some positive comments about the MCOs, including that the MCOs are generally helpful when HHP staff get connected to the right person and that the MCOs have a difficult job. Others remarked that MCO staff feedback during an audit, review or site visit is often very helpful.

HHPs also complained about the Kansas Medical Assistance Program's (KMAP) eligibility portal accuracy. Others stated that KMAP should show to which HHP a member is assigned.

Concerns were voiced about the Department for Children and Families (DCF) Medicaid eligibility workers not being willing to update member records when HHPs alerted them to address changes.

Finally, HHPs demonstrated some basic lack of knowledge about the Medicaid program and which requirements are due to federal regulation or direction. At one meeting a HHP asked that the MCOs relax the spend down requirement. When it was pointed out that the MCOs have not imposed that requirement, another HHP said "No, it's the State." KDHE staff pointed out that it is a federal requirement for states that choose to cover the medically needy population in Medicaid.

Barriers for HHPs

When HHPs were asked what their major barriers were to providing HH services, they repeated the same concerns and issues they raised in response to the previous focus question. Most reiterated the biggest barriers were three sets of expectations and requirements and the amount of administrative work they have to do. Finding members was also cited as a major barrier to providing HH services. Addresses in the State's eligibility system are frequently not current due to the transient nature of the SMI population. Addresses are usually updated during eligibility reviews which generally occur annually, although not even that often for the SSI population.. HHPs also stated MCOs do not always share the most recent addresses they have until a refusal form is sent by the HHP after attempting to contact members. Some HHPs indicated they had tried to provide DCF eligibility workers with updated address information, but it was not accepted.

Next Steps

Some immediate steps that KDHE has taken in response to HHP input from the listening tour include:

- Asking the MCOs to bring information to share with HHPs about value-added services as well as other informational brochures to the May 6th Learning Collaborative meeting
- Asking Wichita State University's Center for Community Support and Research to plan a HH conference, which will take place August 11 and 12, 2015 in Wichita
- Disseminating tips and tricks HHPs share in a regular feature in the monthly newsletter, the *Health Homes Herald*
- Addressing issues related to foster care children assigned to HHs by launching an online survey of HHPs about their experience with such children and providing some training to state foster care contractors staff
- Planning the formation of a HH Advisory Council in early fall 2015

A draft version of this report and details from the 22 listening tour meetings were shared with the three MCOs. A meeting was held July 9, 2015, during which state and MCO staff worked together to prioritize areas for improvement and develop an action plan. Some areas of concern raised by HHPs will not be focused on. The state is committed to contracting with three MCOs, so there will continue to be three Lead Entities for the HH program. Each of them will continue to have their own provider portals. However, each of them is committed to working together to find ways to streamline process where possible. One such way is their commitment at the July 9th meeting to try to develop a single set of audit tools. They have also agreed to draft a HH

orientation and training manual to assist HHPs with training new staff and to serve as companion resource to the SMI Health Home Program Manual. In addition, they will provide more training in the use of their portals. KDHE and the MCOs also agreed to use time available on the biweekly SMI HH Implementation calls to provide short trainings about topics of interest to HHPs.

KDHE and the three MCOs are committed to the SMI HH program and to making improvements wherever possible. We will continue to review and revise forms and instructions as necessary, develop and offer training, and improve understanding of requirements and expectations.

Everyone involved in the implementation of SMI HHs in Kansas can take pride in the program and the benefits it has demonstrated for its members.

Appendix A

Health Home Partner Agencies Represented at Listening Tour Meetings

Agency
Bert Nash Community Mental Health Center
Big Lakes Developmental Center
Central Kansas Mental Health Center
COMCARE of Sedgwick County - Health Links
Community Health Center of Southeast Kansas
Community Living Opportunities, Inc.
Community Mental Health Center of Crawford County (CMHCCC)
Compass Behavioral Health
Cottonwood, Inc.
Disability Supports of the Great Plains, Inc.
Easter Seals Capper Foundation
Elizabeth Layton Center
Episcopal Social Services-Venture House / Breakthrough Club of Sedgwick County
Family Service and Guidance Center
Flinthills Services, Inc.
Four County Mental Health Center
Futures Unlimited
GraceMed Health Clinic
The Center for Health & Wellness of The Center for Counseling & Consultation
HealthCore Clinic
Heart of Kansas Family Health Care, Inc.
High Plains Mental Health Center
Independent Strides Health Home
InMyHome, a division of OCCK Inc.
Iroquois Center for Human Development
Johnson County Health Home
Kanza Mental Health & Guidance Center, Inc.
KETCH
Labette Center for Mental Health Services, Inc.
Lakemary Center, Inc.
MCDS - McPherson
Mental Health Association of South Central Kansas

Agency
Mental Health Center of East Central Kansas
Mirror, Inc.
Mosaic
Multi Community Diversified Services
New Beginnings Enterprises, Inc.
OCCK Inc.
Pawnee Mental Health Services - Health Connect
Prairie View, Inc.
ResCare Kansas Connections
Rose Palms Support Services
Rosewood Services
Sedgwick County Developmental Disability Organization
South Central Mental Health
Southeast Kansas Mental Health Center
Southwest Guidance Center
Spring River Mental Health and Wellness, Inc.
Sumner Mental Health Center
Sunflower Diversified Services
TECH Inc.
The Guidance Center
Twin Valley Developmental Services, Inc.
Valeo Behavioral Health Care
Wyandot Center

Appendix B

HHP Listening Tour Attendance

Location	Attendance
Chanute	9
Dodge City	1
El Dorado	8
Emporia	11
Great Bend	17
Hays	8
Hiawatha	6
Hutchinson	9
Independence	12
Kansas City	19
Lawrence	21
Leavenworth	8
Liberal	4
Manhattan	7
Mission	5
Newton	9
Ottawa	9
Parsons	10
Pittsburg	4
Salina	11
Topeka	9
Wichita	22
Total	219

Appendix C

Health Home Partner Listening Tour
April 20-22 and May 12, 2015
Agenda

1. Introductions and purpose — 10 minutes

2. State presentation of on-line survey data and other information — 15 minutes

3. Focus questions: — 40 minutes
   a. What are you doing to reach out to other community providers (e.g., hospitals, PCPs, foster care contractor case managers)?
   b. How are you marketing yourself to members of the community as a whole?
   c. What do you need from the MCOs to enable you to provide exceptional services to HH members?
   d. Do you find the program manual helpful? Are there additional program-related topics you'd like to see addressed in the manual?

4. Health Home Partner successes and barriers — 45 minutes

5. Wrap up and next steps — 10 minutes